State of California Department of Consumer Affairs

BOARD OF BEHAVIORAL SCIENCES
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Website Address: http://www.bbs.ca.gov

REPORT OF SETTLEMENT, JUDGMENT OR ARBITRATION AWARD

Required by Section 801, 801.1, 802, 803.2 California Business and Professions Code

PLEASE CHECK THE APPROPRIATE BOX:

☐ Section 801 (Insurance Company) ☐ Section 802 (Self-insured)
☐ Section 801.1 (State of Local Government) ☐ Section 803.2 (Employer-Prof. Corp., group practice, health care facility or clinic)

INSURER/PUBLIC ENTITY:

1. Name _____ 2. Telephone _____
3. Address _____

PROVIDER:

4. Name _____ 5. License Number _____
6. Address (es) _____ License Type _____
_____
8. Counsel's Name: _____ 7. Policy Number _____
10. Address _____ 9. Counsel's Phone Number _____
_____

11. NOTE: On reverse, enter full name(s) of other physicians or health care providers who were claimed or alleged to have acted improperly, whether or not such persons were as defendants, or whether or not any recovery or judgment was against such persons. If any monies were paid on behalf of those listed, please indicate the amount.

PLAINTIFF/CLAIMANT:

12. Name _____ DATE: _____
13. Address (es)
Business _____
Residence _____
14. Hospital Name and Address _____
15. Incident Date _____ 16. Date of Admittance _____
17. Patient Name _____ 18. Hospital Chart Number _____
19. Patient Date of Birth _____ 20. Deceased ☐ Yes ☐ No
21. Counsel's Name _____ 22. Counsel's Phone Number _____
23. Address _____

24. Enter on reverse, a description of summary of the facts which each claim, charge or judgment rested including date of occurrence. Explain specifically whether death or personal injury occurred as a result of the negligence, error or omission in practice, or rendering of unauthorized professional services by the insured. Attach additional sheets as necessary. Photocopies of any pertinent documents, which contain this information, may be attached instead.

25. Case Resulted in: (Check one) ☐ Settlement ☐ Judgment ☐ Arbitration Award	26. Date Resolved:	27. Total Amount of Award: $	28. Total Paid on Behalf of Physician:
29. Name and Location of Court/Arbitrator:		30. Filing Date:	31. Docket Number:

I certify under penalty of perjury under the laws of the State of California that to the best of my knowledge the information provided within this report and any attachments is true and correct.

_____ _____
Signature Responsible Agent or Insurer Name and Title (Printed or Typed) Date

11. (Continued):

Name:

License Number:

Address (if available):

24. (Continued):

Summary of facts: